



Welcome to the office of Dr Steven Rosenblat Family, Cosmetic and Implant Dentistry

Hopedale Shopping Centre 2nd floor 1515 Rebecca Street, Suite 220 Oakville, Ontario, L6L 5G8 www.oakdaledental.ca 905 827-0301

MEDICAL ALERT FOR OFFICE

NAME; MR. / MISS / MRS / MS. / DR.

DATE OF BIRTH (DAY / MONTH / YEAR): / /

ADDRESS ( HOME ):

PHONE: (H) (W)

(CELL)

(EMAIL)

OCCUPATION:

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

OR, DID YOU HEAR OF US FROM : INTERNET / YELLOW PAGES / SIGN / NEWSPAPER / OTHER:

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:

RELATIONSHIP

DAY-TIME PHONE:

NAME OF FAMILY DOCTOR:

HEIGHT WIEGHT

MALE FEMALE AGE TODAY

DENTAL INSURANCE COMPANY NAME:

GROUP POLICY #: CERTIFICATE #:

SECONDARY INSURANCE COMPANY NAME:

GROUP POLICY #: CERTIFICATE #:

AFTER COMPLETING ALL PAGES OF THIS QUESTIONNAIRE PLEASE READ AND SIGN THE AUTHORIZATION AND RELEASE BELOW:

I certify that I have read, understood and accurately completed the personal, medical and dental questionnaires to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed by me, and I have had the chance to ask questions and to receive answers regarding any medical and dental histories. As may be required, I consent to my physician being contacted regarding any specific medical questions. I authorize Dr. Rosenblat or his employees to release any information concerning my dental treatment or my child's dental treatment to third party payers and /or other medical/dental offices. I authorize Dr. Rosenblat and his qualified employees to perform necessary diagnostic procedures and treatment as required to achieve the proper level of dental care including the use of local anesthesia and other medication as indicated. I understand that I am financially responsible to the dentist for all costs of dental services provided, regardless of outcome, even if my insurance coverage may not be all inclusive.

PATIENT / PARENT / GUARDIAN SIGNATURE:

DATE:

## MEDICAL HISTORY QUESTIONNAIRE

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. Dr. Rosenblat will review the questions and explain any that you do not understand. Please fill in the entire form.**

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?  
 YES     NO     NOT SURE / MAYBE

2. When was your last medical checkup?  
 \_\_\_\_\_

3. Has there been any change in you general health in the past year? If yes, please explain.  
 YES     NO     NOT SURE / MAYBE

4. Are you taking any medications, non prescription drugs or herbal supplements of any kind? If yes please list them all.  
 YES     NO     NOT SURE / MAYBE


5. Do you have any allergies? If you answer yes, please list using the categories below:     YES     NO     NOT SURE / MAYBE

a. Medications:	i.e., aspirin	dental anesthetics
b. latex / rubber products	codeine	metals
c. other (e.g. hay fever, foods...)	penicillin	

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.  
 YES     NO     NOT SURE / MAYBE

7. Have you ever been hospitalized for any illness or operations? If yes, please explain.     YES     NO     NOT SURE / MAYBE

8. Do you smoke or chew tobacco products?     YES     NO

9.. For women, are you breastfeeding or pregnant?     YES     NO . If pregnant delivery date is: \_\_\_\_\_

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

10. Do you have or have you ever had any of the following? Please check.

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Asthma                         | <input type="checkbox"/> AIDS                | <input type="checkbox"/> Shortness of breath   | <input type="checkbox"/> Seizures (epilepsy)                                 |
| <input type="checkbox"/> Heart problems                 | <input type="checkbox"/> HIV                 | <input type="checkbox"/> Rheumatic fever       | <input type="checkbox"/> Kidney disease                                      |
| <input type="checkbox"/> Blood pressure problems        | <input type="checkbox"/> Liver disease       | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Drug/alcohol dependency                             |
| <input type="checkbox"/> Artificial heart valve         | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Heart murmur          | <input type="checkbox"/> Osteoporosis medications<br>(e.g. Fosamax, Actonel) |
| <input type="checkbox"/> Heart infection                | <input type="checkbox"/> Leukemia            | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Thyroid problems                                    |
| <input type="checkbox"/> Heart condition from birth     | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Lung disease          |  |
| <input type="checkbox"/> Bleeding disorders             | <input type="checkbox"/> Radiation therapy   | <input type="checkbox"/> Tuberculosis          |  |
| <input type="checkbox"/> Heart defects                  | <input type="checkbox"/> Chemotherapy        | <input type="checkbox"/> Steroid therapy       |  |
| <input type="checkbox"/> Heart transplant               | <input type="checkbox"/> Chest pains, angina | <input type="checkbox"/> Diabetes              |  |
| <input type="checkbox"/> Artificial / prosthetic joints | <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Stomach ulcers        |  |
| <input type="checkbox"/> Immune deficiencies            | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Arthritis             |  |

11. Are there any conditions or diseases not listed above that you have had? If so, what?

YES    NO    NOT SURE / MAYBE

### DENTAL HISTORY QUESTIONNAIRE

Are you nervous during dental treatment?  YES    NO

When was you last dental visit?

\_\_\_\_\_

What is the reason for today's visit?

\_\_\_\_\_

Do you love your smile?

\_\_\_\_\_

Is there anything you would like to change?

\_\_\_\_\_

Why did you leave your last dentist?

\_\_\_\_\_

Do you have any missing teeth you would like to replace?  YES    NO

Do you have:

- |   |   |       |
|---|---|-------|
| <input type="checkbox"/> Any pain   | <input type="checkbox"/> Gum swelling?        | _____ |
| <input type="checkbox"/> Loose teeth  | <input type="checkbox"/> Bleeding gums?       | _____ |
| <input type="checkbox"/> Teeth that have shifted  | <input type="checkbox"/> Shifting teeth?      | _____ |
| <input type="checkbox"/> Sensitive teeth to:  | <input type="checkbox"/> Jaw pain             | _____ |
| <input type="checkbox"/> Hot <input type="checkbox"/> cold <input type="checkbox"/> sweet <input type="checkbox"/> biting | <input type="checkbox"/> Clicking/popping jaw | _____ |

Have you ever had:

- |  |       |
|--|-------|
| <input type="checkbox"/> Root canal                      | _____ |
| <input type="checkbox"/> Teeth removed                   | _____ |
| <input type="checkbox"/> Gum surgery                     | _____ |
| <input type="checkbox"/> Implants                        | _____ |
| <input type="checkbox"/> Complications after extractions | _____ |
| <input type="checkbox"/> Problems with local anesthetics | _____ |

**Thank you for completing these forms.**